ANESTHESIA ASSOCIATED WITH HYPERALGESIA SHARPLY CONFINED TO AREOLA-NIPPLE AREA OF BOTH BREASTS: A NEW AND APPARENTLY CONSTANT STIGMA IN HYSTERIA.

By William W. Graves, M.D.,

OF ST. LOUIS.

"Hysteria is a Proteus, assuming many forms, and like the chameleon, shows many colors."—Sydenham. Almost every bodily function may be perverted and organic disease is often so closely simulated by it, that the possibility of hysteria must be frequently reckoned with in neurological examinations. Inconstancy and variability in symptomatology are the chief characteristics of the disease.

Of the subjective symptoms—pain and paresthesia and of the objective symptoms—anesthesia and analgesia are the most constant. Oppenheim states, that pain is never absent in hysteria, and Gendrin was of the opinion that "In every case of hysteria, without exception, from the beginning to the termination of the malady, there exists a condition of anesthesia, general or partial." In four hundred cases observed by Briquet, some degree of anesthesia was found in two hundred and forty, or in sixty per cent. In a more recent series of forty cases, Pitres found sensation to be normal in two, or in only five per cent.

The views of Gendrin have never been fully accepted, for the reason, that it was not uncommon, especially in the interparoxysmal stage, for one to be unable to determine a condition of anesthesia. Anesthesia, general or partial, has, therefore, up to the present time, not been considered a constant symptom of hysteria. The same may be said of the so-called stigmata, and of these, corneal and pharyngeal anesthesia and *ovarie* are the most constant; but these may be present in otherwise normal individuals and they are often absent even in well-marked cases of hysteria, and hence are of little value in differential diagnosis. Certain visual anomalies and the characteristic sensory disturbances, when present, are pathognomonic of hysteria, but the former is less constant than the latter, and both are often absent. Even the hysterical temperament or mental state is not always sharply defined. Thus it is, that inconstancy and variability are expressive of all hysterical symptoms and stigmata, thus far recognized, and are equally expressive of the disposition and the mental state of the hysterical individual.

I have recently observed a peculiar sensory disturbance nowhere recorded in neurological literature, and one which is apparently constant in hysteria.

About one year ago, while making a sensory examination of a female aged forty-two, whom I had known for many years, and had frequently attended in hysterical fits, and in divers other hysterical manifestations, the only objective sensory disturbance found was anesthesia associated with hyperalgesia sharply confined to the areola-nipple area of both breasts. The tests were made with a fine wisp of absorbent cotton, and the pointed end of a rather large safety pin. Touch and pin-pricks were promptly recognized and accurately localized throughout, excepting within the areola-nipple areas, where touch was not recognized, but pin-pricks were said to be, and appeared to be more painful than to the adjacent skin. The anesthetic and hyperalgesic area was separated from the normal with hair line sharpness—and this line was represented by the skin-areola margin. Within the hyperpigmented area anesthesia and hyperalgesia were present—beyond it normal sensation.

Such findings were unknown to me and little importance was attached to these at the time, other than to consider them as objective evidence of the malady in question in this particular patient. Nevertheless, I was so impressed with the findings that I have made it a rule since then, in both private and clinic work to note especially the state of sensation of the areola-nipple areas in every individual coming under my observation. I have also made similar examinations in quite a number of healthy and apparently normal individuals of both sexes, varying in age from six to eighty years. My observations thus far have shown: (1) That in no normal individual was this sensory disturbance found; on the contrary, the majority of these claimed to perceive touch more, and painful impressions less acutely in the areola-nipple area than in the surrounding parts, whereas others noticed little or no difference. (2) That it was not present in any organic disease, neurosis or psychosis unless hysteria was a complication and the diagnosis of such complication was made independently of it. (3) That in every case of hysteria, thirty in all, six males and twenty-four females, including the mildest and severest examples of the malady, two of the males having traumatic hysteria, areola-nipple anesthesia associated with hyperalgesia was invariably present, conforming in a striking manner to my first observation recited above.

The presence of areola-nipple anesthesia associated with hyperalgesia was confirmed by my colleagues Drs. Frank R. Fry, and Sidney I. Schwab, in several of the above-mentioned cases, and also observed in several of their own; otherwise, I should have greatly hesitated to give it publicity at this early date. When, however, others are able to confirm one's observations, self-deception is to a certain extent eliminated, but the diagnostic value of an observation can only be determined by time and in the crucial balance of general experience.

My own experience compels me to consider areola-nipple anesthesia associated with hyperalgesia as a pathognomonic and practically constant stigma in hysteria, and should the observations of others prove confirmatory of its presence and constancy an additional objective diagnostic aid will be at our command, whereby we may be better enabled to differentiate between the so-called functional disorders, and between the hysterical and the organic.